American Family Life Assurance Company of Columbus (AFLAC)

Worldwide Headquarters: 1932 Wynnton Rd., Columbus, Georgia 31999-7251
Toll-Free 1-800-99-AFLAC (1-800-992-3522) or visit our web site at www.aflac.com

INSTRUCTIONS FOR FILING CLAIMS

* Select the type of claim being filed and follow the instructions.
* Include your policy number(s) on the documents being submitted.
* If confined in a government hospital, the hospital will provide you with Form #544 or UB92.

You may fax your claim to our toll free fax number 1-877-44-AFLAC (1-877-442-3522)
or
Mail all forms to: American Family Life Assurance Company of Columbus (AFLAC)
ATTN: Claims Department
Worldwide Headquarters: 1932 Wynnton Rd.
Columbus, Georgia 31999-7251

For Information, call toll-free at 1-800-99-AFLAC (1-800-992-3522)

* **CANCER CLAIMS:**

  A pathology report diagnosing cancer **must** accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made by clinical information instead of pathological means, please submit the clinical evidence that established the diagnosis of cancer.

  Include a copy of your itemized hospital billing if you were hospitalized.

  Have the doctor complete the Physician's Statement and attach an itemized billing showing the diagnosis, services rendered and the actual charges made to you. (Form S-2029).

  Any other bills pertaining to this claim, such as anesthesia, radiation treatments, ambulance, nurses (RNs or LPNs) may be forwarded to this office.

* **DREAD DISEASE:**

  A tissue specimen, culture(s) and/or titer(s) or other diagnostic studies which initially diagnosed the dread disease must accompany your first claim. Include a copy of your itemized hospital billing and Physician's Statement. (Form S-2029).

* **INTENSIVE CARE CLAIMS:**

  Please send a copy of your hospital bill showing charges and number of days in the intensive care unit.

  If the hospital bill fails to give the diagnosis, the Physician's Statement must be completed by the doctor. (Form S-2029).

  A copy of the police report is required for all accidents investigated by any law enforcement agency.

* **HOSPITAL INDEMNITY:**

  Send us a copy of your hospital bill giving the number of days confined. Your claim cannot be processed without the hospital billing.

  The Physician's Statement must be completed by the doctor in its entirety (Form S-2029).

  A copy of the police accident report is required for all accidents investigated by any law enforcement agency.

  We may require additional information to complete your claim.

* **PERSONAL SICKNESS INDEMNITY:**

  Complete and Sign the Physician Visit Benefit letter. Benefit letters are sent with the original policy, with the Explanation of Benefits or can be obtained by calling **1-800-99-AFLAC (1-800-992-3522)**.

* **HOME HEALTH CARE / ADULT DAY CARE:**

  Complete Part 1 and sign the Authorization to Release Information (Form H-C0020).

  Have Part 2 completed by attending physician.

  Have Part 3 completed by the home health care / adult day care provider and attach an itemized billing showing the dates, type of services and charges incurred.

* **LONG-TERM CARE/CONVALESCENT CARE:**

Complete Part 1 of the Long-Term/Convalescent Care Claim Form and sign the Authorization to Release Information (Form A-14284).

Have Part 2 completed by the attending physician.

Have Part 3 completed by the director of nursing at the long-term care facility.

Attach a billing from the long-term care facility showing the dates of admission and discharge and charges incurred.

* **MEDICARE SUPPLEMENT:**

Medicare now files claims electronically. Contact your provider for information regarding participation in this program.

Send us a copy of your Medicare "Explanation of Benefits" form (EOMB).

When filing for Medicare Part A, please send the Medicare "Explanation of Benefits" form (EOMB), along with the UB92.

In some cases, we may contact you for additional information.

* **SPECIFIED HEALTH EVENT:**

Send us a copy of your hospital bill giving the number of days confined.

The Physician's Statement must be completed by the doctor in its entirety (Form S-2029).

A copy of the police accident report is required for all accidents investigated by any law enforcement agency.

Any other bills pertaining to the claim, such as physical therapy, rehabilitation, home health care, speech therapy, ambulance may be forwarded to this office.

We may require additional information to complete your claim.

* **ACCIDENT CLAIMS:**

- ☐ A copy of the hospital bill. Make sure the bill includes your diagnosis and the number of days you were in the hospital. If you were treated in the emergency room or a doctor's office, send us a copy of these bills also.
- ☐ Section A: Patient Information at the top of the Accident and Disability Claim Form (form S-00198) should be completed and signed by you.
- ☐ Section C: Doctor's Information on the back of the Accident and Disability Claim Form (form S-00198) should be completed and signed by your doctor.

We may also need:

- ☐ A copy of the **accident report** if the accident was investigated by the police or sheriff.
- ☐ A copy of the **blood alcohol report** or **drug screening** if the patient was tested for alcohol or drugs.
- ☐ A **certified copy of the death certificate** if the patient is deceased.

* **FIRST CLAIM FOR DISABILITY due to Accident or to Sickness:**

- ☐ **Section A: Patient Information** at the top of the Accident and Disability Claim Form (form S-00198) should be completed by you.
- ☐ **Section B: Employer's Information** at the bottom of the Accident and Disability Claim Form (form S-00198) should be completed, including your monthly salary and pre-tax information, and signed by your employer.

  If you are self-employed, also send us a copy of your current business license and your most recent quarterly tax records. Additional information may be required.
- ☐ **Section C: Doctor's Information** on the back of the Accident and Disability Claim Form (form S-00198) should be completed and signed by your doctor.

* **SECOND AND SUBSEQUENT CLAIMS FOR DISABILITY** (If you are still disabled and we have already paid you once for this disability)

- ☐ **Section A: Patient Information** at the top of the Continuing Disability Claim Form (form S-13270.1) should be completed by you.
- ☐ **Section B: Doctor's Information** in the middle of the Continuing Disability Claim Form (form S-13270.1) should be completed and signed by your doctor.
- ☐ **Section C: Employer's Information** at the bottom of the Continuing Disability Claim Form (form S-13270.1) should be completed and signed by your employer.